(X3) DATE SURVEY

Division of Health Care Facilities

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMI	SURVEY	
		TN8001		B. WING			R 05/2018
NAME OF PROVIDER	OR SUPPLIER				TATE, ZIP CODE		
CONCORDIA NUI	RSING AND REHA	ABILITATION.		TH CARE DE SE, TN 3703			
	CH DEFICIENCY MUS	ENT OF DEFICIENCIES OF BE PRECEDED BY ENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
11/14/2 09/24/2 correct found.	Safety revisit sun 018 for the previ 018. The deficient ed, and no new r	vey was conductorious deficiencies encies have been non compliance with urveyed.	cited on n was	{N 000}			

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 11/16/2018 FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 01 - MAIN BUILDING 01 R B. WING 11/14/2018 TN8001 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 112 HEALTH CARE DR CONCORDIA NURSING AND REHABILITATION-CARTHAGE, TN 37030 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {N 000} {N 000} Initial Comments A Life Safety revisit survey was conducted on 11/14/2018 for the previous deficiencies cited on 09/24/2018. The deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all state licensure regulations surveyed.

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:	B. WING		(X3) DATE SURVEY COMPLETED 09/24/2018	
		TN8001				
NAME OF PR	OVIDER OR SUPPLIER		DDRESSI CITY, S	TATE, ZIP CODE		
CONCOR	DIA NURSING AND	REHABILITATION,	GE, TN 3703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETI DATE

DIVISIO	Torricatir care rasmass			
N 000	Initial Comments	N 000		
N 831	A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 09/24/2018. During this Life Safety Survey, Concordia Health and Rehabilitation of Smith County was found not in substantial compliance with the requirements of the Tennessee Rules and Regulations 1200- 08-06, Standards for Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). 1200-8-608 (1) Building Standards (1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured.	N 831		
	This Rule is not met as evidenced by: Based on observation, the facility failed to maintian the physical plant and overall enviroment. The finding included			
	Observation on 09/24/2018 at 3:59 PM, revealed the protective cover not properly attached to the wall mounted heating and air-conditioning unit in room 708 (cover falling off of unit).			
	Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 09/24/2018.			#1
	ealth Care Facilities v DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN	IATI IAF	ŦŀŦĿĔ	^{(X6} DATE
ABUKATUK	I DIVICTOR 3 ON SKONIDER/2055FIER KERKESENTATIVE-3 3101	ATONE		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
	TN8001	B. WING	09/24/2018

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION : 02 - STATE BUILDING	DATE SURVEY COMPLETED
		TN8001	B. WING	_	09/24/2018
IAME OF	PROVIDER OR SUPPLIE	R STREET ADD	DRESS, CITY, S	TATE, ZIP CODE	
		112 HEAL	TH CARE D	R	
CONCOR	RDIA NURSING AND I	REHABILITATION,			
		CARTHAG	SE, TN 3703	30	
PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMP

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE

112 HEALTH CARE DR CONCORDIA

NURSING AND REHABILITATION.

PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE
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N1410	1200-8-614(2)(a)5.(ii) Disaster	N1410		
	Preparedness			
	(2) Physical Facility and Community			
	Emergency			
	Plans.			
	(a) Physical Facility (Internal Situations).			
	5. Each of the following disaster preparedness plans shall be conducted annually prior to the month listed in the plan. Drills are for the purpose of educating staff, resource determination, testing personnel safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.			
	(ii) External disaster procedures plan (for tornado, flood, earthquake), to be exercised prior to March, shall include:			
	(I) Staff duties by department and job assignment; and,			
	(II) Evacuation procedures.			
	This Rule is not met as evidenced by: Based on dcument review, the facility failed to exercise and evaluate the disaster plans for all staff.			
	The findings included		×	
	During the document review on 09/24/2018 at 1 .•40 AM, the facility could not provide written documentation and evaluation of staff during the following disaster plans:			
	a. tornado.			
	b. earthquake.			
	ealth Care Facilities DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN	ΔTURF	TITLE	(X6) DATE
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FORM

If continuation sheet 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION 02 - STATE BUILDING		SURVEY
		TN8001	B. WING		09/2	4/2018
NAME OF P	ROVIDER OR SUPPL	IER STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		112 HEA	LTH CARE D	R		
CONCOR	DIA NURSING AND	REHABILITATION				
		CARTHA	GE, TN 3703	0		1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETI DATE

N1410	Continued From page 1	N1410	38	
	Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 09/24/2018.			
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Division of Health Care Facilities

If continuation sheet 2